MONKEY MOUTHS

pediatric therapy

Occupational Therapy Child History Form

Date:_____
Child's Name:_____
Child's Age: _____
Date of Birth:_____
Parent's Name:_____
Phone: (Home)_____(Work)_____
Email:_____
Emergency Contact:_____
Child's Address:_____
Child's Doctor:_____
Sisters and Brothers in the household:
Name: Age:
_____
_____
_____
_____
Name of the person completing this form:_____
Relationship to child:_____

STATEMENT OF THE PROBLEM:
Reason for referral:
_____
_____
_____

Describe the problem:
_____
_____
_____

Monkey Mouths
1809 Precinct Line Rd.
Hurst, TX 76054

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370 S State Hwy 121 Ste. 105
Coppell, TX 75019

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Fort Worth, TX 76132

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Is this the first OT evaluation for your child? Yes No
If not, who else has seen this child? (Who , When, Outcome)

_____
_____
_____

What skills do you hope your child will gain if therapy is warranted? What does your child want to learn to do that they currently can't?

_____
_____
_____

MEDICAL HISTORY:
Were there any problems during pregnancy, birth or delivery? Yes No
If so, please explain:

_____
_____
_____

Was your child born prematurely? Yes No
If yes, at how many weeks? _____

Is there any history of medical concerns? Yes No
Please describe any medical concerns, injuries, illnesses, or surgeries:

_____
_____
_____
_____

Has hearing been tested? Yes No
Where?_____
When?_____
Results_____
_____

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Has vision been tested? Yes No
Wears Glasses: Yes No
Where? _____
When? _____
Results_____
_____

Please list any medications your child is currently taking:
_____
_____
_____
_____

DEVELOPMENTAL MILESTONES
Age child began to roll: _____
Age child sat unsupported: _____
Age child walk / ran: _____
Age child began to ride a tricycle/bike: _____
Age child began to feed themselves finger foods: _____
Age child began to use feeding utensils:_____
Age child began to use writing utensils (colors/pencils)_____

Briefly describe your child's ability to:

Participate in age level self-care skills (items can include dressing, feeding, grooming, buttons and shoe tying):_____
_____
_____

Participate in age level eye-hand coordination tasks (items can include sports participation, handwriting abilities and scissoring):_____
_____
_____

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Participate in school related activities (reading, spelling, math):_____
_____
_____

Any current school environment modifications? _____
_____

Briefly describe any behavior problems:_____
_____
_____
_____

Briefly describe any fine motor concerns:_____
_____
_____

Briefly describe any gross motor concerns:_____
_____
_____

Has your child been evaluated by other professionals (i.e. Speech Therapy, Physical Therapy, Psychology, etc.)? Yes No
If so, please explain:
_____
_____
_____

INTEREST INVENTORY:
What are your child's interests and favorite activities?
_____
_____
_____

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Does your child have any fears or sensitivities to sensory stimuli (i.e. lights, loud noises, textures)?

_____

_____

Does your child receive special help in school? Yes No
If so, please explain:

_____

_____

_____

Is there anything else you wish to add that would help insure a positive testing experience for your child?

_____

_____

_____

_____

Is there any additional information or concerns that would help us to get to know your child better?

_____

_____

_____

_____

Thank you very much for your help and for the information you provided in this case history form. If you have questions before your intake or diagnostic appointments, please contact us at (817) 479-7019.

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